| | | | |
|---|---|---|---|
| **Document Title:** | **UROLOGY CLINICAL OPERATIONAL POLICY** | | |
| **Document Reference/Register no:** | 10114 | **Version Number:** | 3.0 |
| **Document type:** (Policy/ Guideline/ SOP) | Guideline | **To be followed by:** (Target Staff) | All Staff |
| **Ratification Issue Date:** (Date document is uploaded onto the intranet) | 5th September 2019 | **Review Date:** | 4th September 2022 |
| **Developed in response to:** | Best Practice Health and Social Act 2008 | | |
| **Contributes to HSC Act 2008** (Regulated Activities) Regulations 2014(Part 3); and CQC Regulations 2009 (Part 4) **CQC Fundamental Standards of Quality and Safety:** | 10, 13, 17 | | |
| **Issuing Division/Directorate:** | Division 2: Surgical | | |
| **Author/Contact:** (Asset Administrator) | Jo Shingler, Consultant Nurse | | |
| **Hospital Sites:** (tick appropriate box/es to indicate status of policy review i.e. joint/ independent) | ✓ MEHT<br>☐ BTUH<br>☐ SUH | | |
| **Consultation:** | (Refer to page 2) | | |
| **Approval Group / Committee(s):** | n/a | **Date:** | n/a |
| **Professionally Approved by:** (Asset Owner) | Daniel Swallow, Clinical Lead Urology Consultant | **Date:** | 29th August 2019 |
| **Ratification Group(s):** | DRAG Chair's Action | **Date:** | 5th September 2019 |
| **Executive and Clinical Directors** (Communication of minutes from Document Ratification Group | **Date:** September 2019 | **Distribution Method:** | Intranet & Website |

| Consulted With: | Post/ Approval Committee/ Group: | Date: |
|---|---|---|
| William McAllister | Urology Consultant | August 2019 |
| Martin Nuttall | Urology Consultant | |
| Rowan Casey | Urology Consultant | |
| Amanda Hammond | Urology CNS | |
| Loraine Simpson | Urology CNS | |
| Louise Baker | Urology CNS | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| **Related Trust Policies** (to be read in conjunction with) | 08092 Mandatory Training Policy<br>MSEPO-19007 Fire Safety Policy<br>09030 Health and Safety Policy<br>08086 Clinical Record Keeping Standards Policy<br>MSEPO-18003 Overarching Information Sharing Protocol<br>05118 Chaperone Policy<br>08078 Lone Worker<br>04051 Security policy<br>04061 Risk management policy |
|---|---|

| Document Review History: | | | |
|---|---|---|---|
| **Version No:** | **Authored/Reviewer:** | **Summary of amendments/ Record documents superseded by:** | **Issue Date:** |
| 1.0 | Urology Consultants | | 2010 |
| 2.0 | Urology Consultants/Lead Nurse | | 2014 |
| 3.0 | Amanda Hammond | Full Review | 5th September 2019 |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Index

**1. Purpose**

**2. Aims of the Service**

**3. Scope of the Service**

**4. Work Flows**

**5. Key Relationships**

**6. Staffing**

**7. MDT Function**

**8. Co-ordination of Care / Patients Pathways**

**9. Training and Education**

**10. Written Information for Patients**

**11. Equipment Requirements**

**12. Contingency**

**13. Responsibilities**

**14. Urology cancer trials**

**15. References**

**16. Appendices**

Appendix 1 Emergency admissions Pathway

Appendix 2 Elective admissions Pathway

Appendix 3 Outpatient Clinic Pathway

Appendix 4 Renal stone Pathway

Appendix 5 Lithotripsy pathway

Appendix 6 Theatre Timetable

Appendix 7 Equality Impact Assessment Form (EIA)

Appendix 8 Radiology Flow pathway

Appendix 9 Admission Criteria for Children in Mid Essex Hospitals

Appendix 10 Urology cancer studies

# 1. Purpose

1.1 To outline the purpose and function of the urology services at MEHT.

1.2 As part of the sustainability MSB configuration the urology service is proposing a configuration with Southend and Basildon in order to create a 24/7 comprehensive regional urology service across mid and south Essex. Following this configuration this document will be revised.

# 2. Aims of the Service

2.1 To provide high quality in-patient and out-patient facilities for patients requiring urological investigation and intervention. The service provides access to consultant urologists and specialist nurse teams via the Trust's out-patient clinics and provides both elective and emergency in-patient care.

2.2 The service provides uro-oncology services, by links with specialist consultants within the Trust and also from Southend Hospital for pelvic cancer surgery and specialist nurses in the area of Uro-oncology.

2.3 The service is also responsive to in-patient consultation requests from other clinical teams to facilitate appropriate specialist management of urological conditions and expedite discharge.

2.4 The department aims to conform to the Health Act 2006: Hygiene code in relation to infection prevention and control measures.

2.5 The Urology Service aims to meet best practice guidelines in effective and efficient treatment of all urological conditions, both electively and emergencies to maximise outcomes by achieving the national standards set against them. The department aims to meet the national upper quartile Length of Stay for these conditions. The department aims to achieve the national standard for new to follow ups and day case rates within Urology Services.

# 3. Scope of the Service

## 3.1 Urology Inpatient / Day Case departments

3.1.1 Elective inpatients are to be treated on a 32 bedded ward, Rayne Ward, A304. These are scheduled operations on one of the twelve urology theatre sessions per week. Theatre capacity is reviewed on a weekly basis to meet the demands of the service and additional theatre sessions are discussed at the theatre user group meeting regarding decisions of extra sessions.

3.1.2 Day case patients are to be treated on ward B344, Day Stay Admissions Unit and A304, Theatre Admissions Surgical Unit. Further day cases are treated at Braintree Community Hospital.

3.1.3 Emergency inpatients are to be treated on emergency short stay and ambulatory ward. The surgical assessment ward, a 16 bedded ward will accommodate patients

with a less than 24 hour projected length of stay. Operations take place in the theatre sessions listed above unless it is an extreme emergency where they are treated on the emergency surgery lists.

3.1.4 The Urology Service also has access to robotic surgery procedures. These are currently undertaken in urology for pyeloplasty, benign nephrectomy, adrenalectomy and radical prostate patients.

3.1.5 Robotic prostatectomy, pyeloplasty and adrenalectomy are a regional service for Mid South Essex (MSE).

3.1.6 Three of the urology consultants carry out major cancer cases at the cancer centre in Southend.

3.1.7 Urology collaborates with interventional radiology to provide a percutaneous renal cryoablation service.

3.1.8 Private patient admissions are arranged via the private patients' office in accordance to the Trust's 'Private patient policy'; register number 12024.

3.1.9 Theatre Template Appendix 5

3.2 **Urology Outpatients**

3.2.1 Hours of service – 09:00 – 18:00, Monday to Friday

3.2.2 **Inclusions**

- 2 week wait fast track clinics;
- One stop haematuria clinics;
- New patient clinics;
- Surgical follow-up clinics;
- General follow-up clinics;
- Diagnostic clinics;
- Results clinics;
- Surveillance clinics;
- Joint oncology clinics;
- Extracorporeal Shock Wave Lithotripsy (ESWL);
- Instillation clinics;
- Paediatric clinics;
- Outreach clinics to Braintree and Maldon.

3.3 **Key services:**

3.3.1 Flexible cystoscopy and renal ultrasound for haematuria

3.3.2 Renal cancers and renal surveillance

3.3.3 Renal and bladder stone service

3.3.4 Diagnostic Transrectal ultrasound guided biopsy for elevated PSA and abnormal rectal examination

3.3.5 Diagnostic urodynamic & video urodynamic clinics confirming bladder outflow obstruction and bladder instability

3.3.6 Catheter management clinics, providing services for GP's, theatres, medical and surgical wards

3.3.7 Joint oncology clinics – supporting patients with new diagnosis of urological cancers

3.3.8 Bladder instillation clinics for administering bladder chemotherapy and immunotherapy for bladder cancer and bladder instillations for interstitial cystitis

3.3.9 Prostate assessment clinics for male lower urinary tract symptoms where uro-flow tests and post void scans are performed

3.3.10 Intravesical Botox instillation clinics for bladder instability

## 4.0 Work Flows – Out-Patients

4.1 One stop haematuria:

- Patient referred by GP via choose and book with haematuria on a 2 week wait referral;
- Appointment is confirmed on choose and book via the Clinical Nurse Specialists;
- On arrival they provide a urine sample to exclude a urine infection;
- Full medical, drug and social history is taken;
- A flexible cystoscopy is carried out to inspect the bladder to exclude any sinister cause for haematuria;
- A renal ultrasound is carried out to observe the bladder and upper renal tract to exclude any pathology;
- Patient is listed for a bladder biopsy of bladder resection if a bladder tumour is suspected of found on cystoscopy;
- If a renal tumour is detected, patient is discussed at MDT;
- Patient is seen by uro-oncology CNS for holistic needs assessment and support
- Histology via MDT;
- A CT scan is requested to confirm no other pathology in the upper tracts.

4.2 One stop testicular:

- Patient is referred by GP via choose and book on a 2 week wait referral with a scrotal abnormality;
- A full medical, drug and social history taken;
- Scrotal examination carried out;
- Scrotal ultrasound carried out;
- On suspicion of sinister pathology, bloods are taken for alpha-fetoprotein (AFP), beta human chorionic gonadotropin (ß-HCG) and lactate dehydrogenase (LDH);
- Sperm banking is organised as a matter of urgency;
- List admission for surgery for removal of testis;

- Patient is seen by uro-oncology CNS for holistic needs assessment and support;
- Histology via MDT.

4.3 2 week wait suspected prostate cancer:

- Patient is referred by GP via choose and book on a 2 week wait referral;
- Full medical, drug and social history taken;
- Rectal examination carried;
- If suitable an MRI and a trans rectal prostate biopsy is requested under local anaesthetic;
- If appropriate the patient is listed for an alternative transperineal prostate biopsy under general anaesthetic;
- Patient is seen by uro-oncology CNS for holistic needs assessment and support;
- Histology and imaging reviewed at MDT.

4.4 Renal stone service – Extracorporeal Shock Wave Lithotripsy (ESWL):

- Patient referred from GP or via accident and emergency department with renal stone;
- Full medical, drug and social history taken;
- CT imagine to confirm size and positioning of stone;
- Suitability for mid and upper pole stones 4mm-10mm in kidney or ureter;
- Listed as a day case (refer to Appendix 5);
- Rebooked for further ESWL sessions (max 3) if tolerated well and procedure effective;
- Rebooked into clinic if unsuccessful treatment for consideration/booking for Flexible Ureteronoscopy and Laser to stone under general anaesthetic.

4.5 Emergency Flows refer to Appendix 1.

4.6 Elective Flows refer to Appendix 2.

4.7 Out-patient Flow refer to Appendix 3.

4.8 Stone clinic refer to Appendix 4.

4.9 Equality Impact Assessment Form (EIA) Form refer to Appendix 6.

4.10 Radiology Flow refer to Appendix 7.

4.11 Admission Criteria for Children in Mid Essex Hosptial refer to see Appendix 8.

## 5.0 Key Relationships

5.1 The urology centre requires ease of access to IT, pathology, radiology and phlebotomy services and chemotherapy team.

5.2 **Key operational requirements:**

- Adherence to all national guideline in respect to urological cancers and benign conditions;
- Access to local laboratory;
- Patient's notes must be available for clinic appointment;
- Data security and records management.

5.3 **Key relationships with other departments:**

- DSU;
- Theatres Medical records staff;
- Ward staff;
- Radiology department Histopathology staff Nuclear medicine department;
- Oncology team;
- Chemotherapy and radiotherapy teams.

5.4 **Key requirements for Facilities Management:**

- Cleaners;
- Transport;
- Support from estates for maintenance;
- Support from MBE for servicing of equipment.

5.5 **Way finding:**

- Clear defined departmental signage from the atrium to the urology centre;
- Written directions are provided to the patients with their appointment letter.

5.6 **Security requirements**

**Data security:**

- The service will be delivered in accordance with and compliance to the Trust's IT policies;
- Data sharing agreements will be drawn up to cover all data sharing outside the Trust in accordance with the Trusts' MSBPO-18003 Overarching Information Sharing Protocol;
- Hospital information and patient data will only be downloaded onto devices provided by the trust which are encrypted;
- Databases will be registered on the trust database of databases;
- Patient identifiable information will only be sent out of the Trust from an nhs.net account or other secure route;
- Out of hours, the urology centre should be made secure.

5.7 **Security for patients**

- The service will be delivered in accordance with and compliance to the trust's patient safety policies;
- All staff must be screened through HR for a CRB check;
- All staff must wear a name badge and carry a Trust ID;

- All patients are chaperoned according to the Trust Chaperone Policy; register number 05118.

### 5.7 Security for staff

- The service will be delivered in accordance with and compliance to the Trust's Lone Worker; register number 08078 and Security policy; register number 04051 and Risk management policy; register number 04061;
- Security for patients and staff – when necessary. Trust based security is available for patients and staff via the emergency phone / bleep numbers.

## 6.0 Staffing

### 6.1 Symptomatic Staff

| Staff Group | Band | Funded WTE |
|---|---|---|
| **Urology Services Management** | | |
| Consultant Nurse | 8b | 1.00 |
| **Urology Medical / Senior Nursing Teams** | | |
| Consultants | N/A | 5.00 |
| Associate Specialists | N/A | 0.48 |
| Speciality Registrars | N/A | 2.0 |
| Specialist registrar | N/A | 1.0 |
| Trust registrar | N/A | 2.0 |
| ST2/FY1/2's | N/A | 4.0 |
| Consultant PA's | Band 4 | 2.2 |
| Support Secretary | Band 3 | 2.0 |
| CNS | 7 | 2.8 |
| Uro-Oncology CNS | 7 | 2.0 |
| RGN | 5 | 2.85 |
| HCA | 2 | 6.77 |

### 6.2 Core urology MDT Membership

| | Core members | Named cover |
|---|---|---|
| Urology consultants | Rowan Casey<br>Bill McAllister<br>Martin Nuttall<br>Danny Swallow<br>Karan Wadhwa | All core members |
| Oncologists | Dr Abdul Hamid<br>Dr Isabel Maund | |
| Radiologists | Dr Skandadas Ganeshalingam | Dr Mohammed Abdallah |
| Uro-oncology CNS | Amanda Lewis<br>Stephanie Clark | |
| Histopathologists | Sarah Lower | |

| MDT co-ordinator | Sian Gooding<br>David Clapp | |
|---|---|---|
| Research nurses | Brian Singazi | |

## 7.0 The MDT function

7.1 The MDT is a team of specialised clinicians working collaboratively to ensure a co-ordinated approach to treatment and care pathways for all patients diagnosed with urology cancer or pre-malignant disease. Any complex benign cases are discussed as well as management of recurrence and metastatic disease where appropriate.

7.2 All patients with a suspected urology cancer are discussed at the MDT following the clinic appointment, after surgery and after investigations.

7.3 The attendance at all meetings is recorded.

7.4 The core MDT members agree and record individual patient treatment plans in accordance with IOG guidelines.

7.5 A record of all patients discussed is kept in addition to the treatment plans.

7.6 Patients are recorded on the Somerset, the national database.

## 8.0 Co-ordination of Care / Patient Pathways

8.1 The service follows the network agreed guidelines for referrals, imaging, pathology and follow-up.

8.2 The NSSG have agreed clinical and referral guidelines which the team adhere to.

## 9.0 Training and Education

9.1 Mandatory training for all staff.

9.2 Medical and senior nursing staff will have undergone advanced communication.

## 10.0 Patient Communication

10.1 All patients diagnosed with a urological cancer will be allocated a key worker.

10.2 All patients that attend a clinic appointment are sent a copy of the GP letter.

10.3 All patients have access numbers to key staff members such as the clinical nurse specialists, medical secretaries, MDT co-ordinator and admin co-ordinator.

## 10.0 Written Information for Patients

10.1 Patients will receive written information from their consultation in preparation for their diagnostic tests and surgical procedures.

## 11.0 Equipment Requirements

BK Medical ultrasound scanner;
Laborie Clinic + urodynamics machine;
Olympus Visera pro stack system;
9 Olympus flexible cystoscopes;
Computers;
Dinamap V100 BP machine / Welch Albyn BP machine;
Printers – reception and medical secretary office;
Computers in all clinic rooms and offices;
Telephones in all clinic rooms and offices;
Projector – Consultants office.

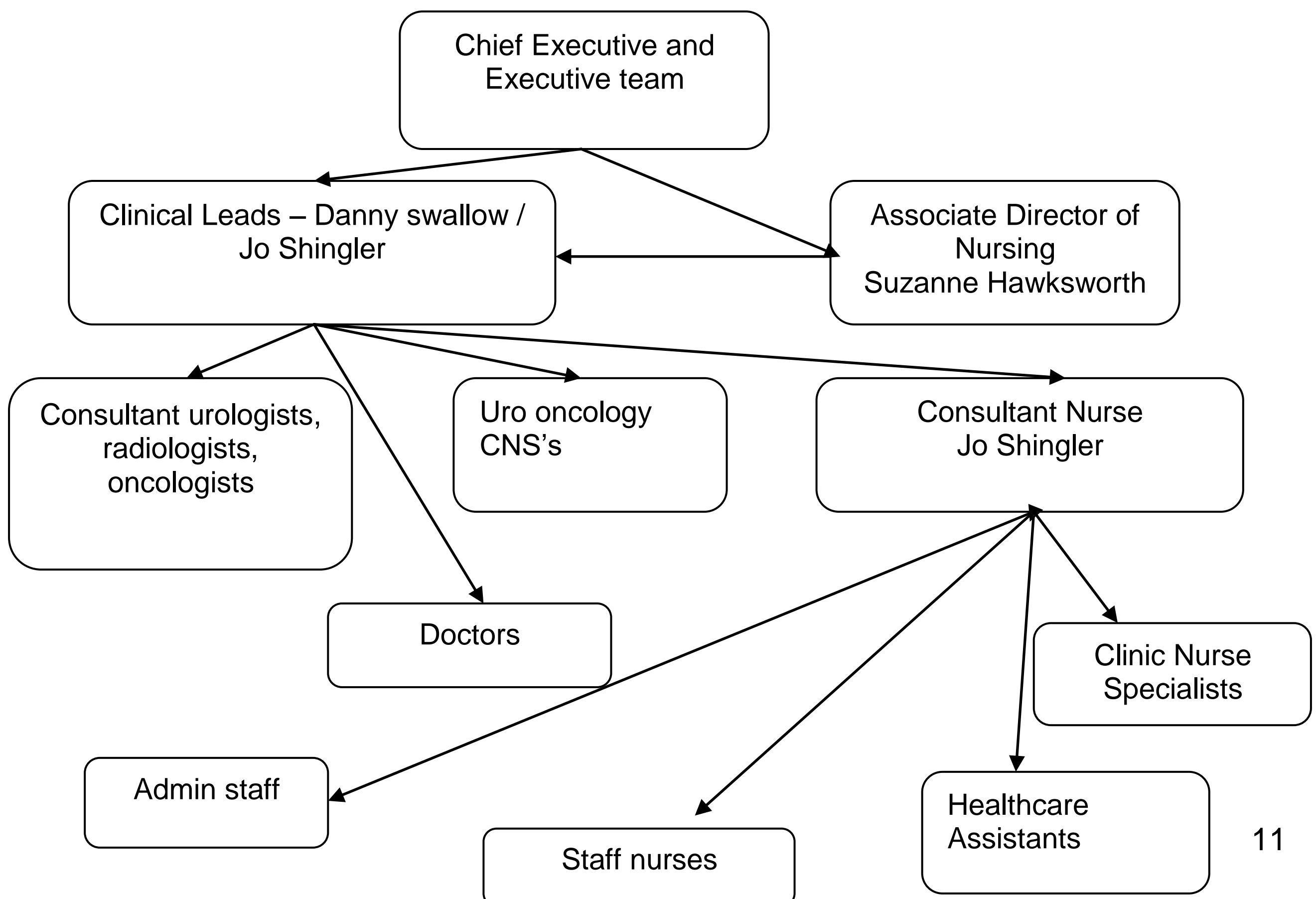
## 12.0 Contingency

12.1 Adverse weather Conditions:

- Clinics will run as normal as long as staff can get to work;
- Extra clinics will be arranged for those cancelled.

## 13.0 Responsibilities

13.1 **Urology Centre Management Team**



## 14. Urological Cancer Studies

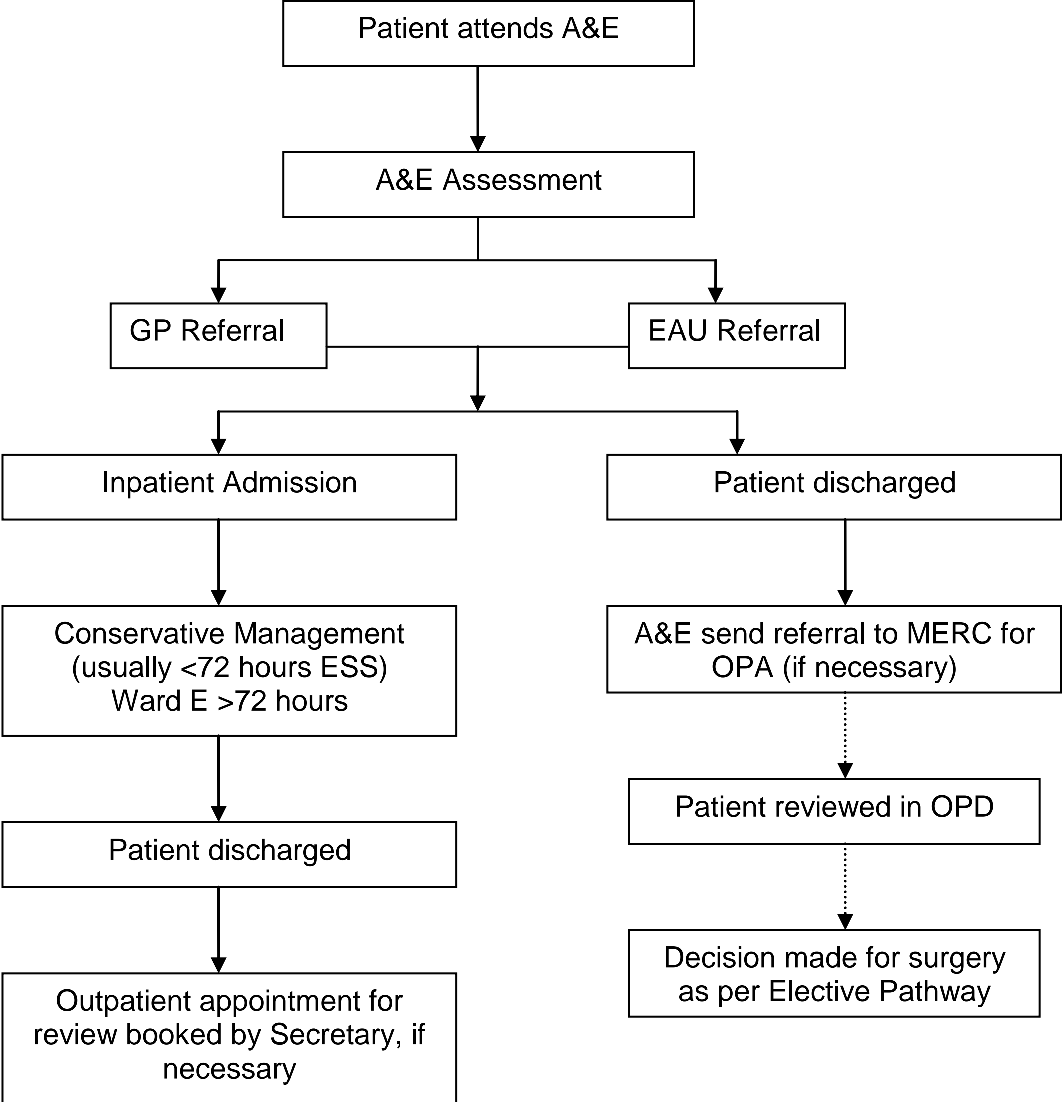
14.1 The urology clinicians support several cancer trials refer to Appendix 10.

## 15. References

NICE guidance
18 weeks referral to treatment guidance
National Standards Framework
Cancer Guidelines
The Health Act 2006
MEHT Infection and Prevention Policy

## Work Flow Diagrams: Emergency Admissions

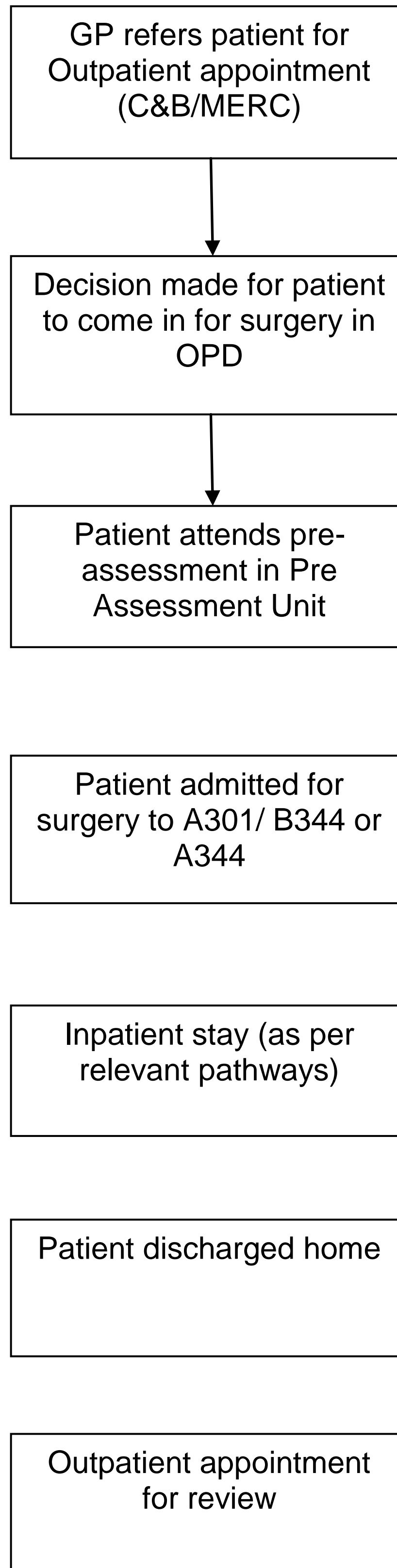
### Emergency Admissions – Pathway



**Appendix 2**

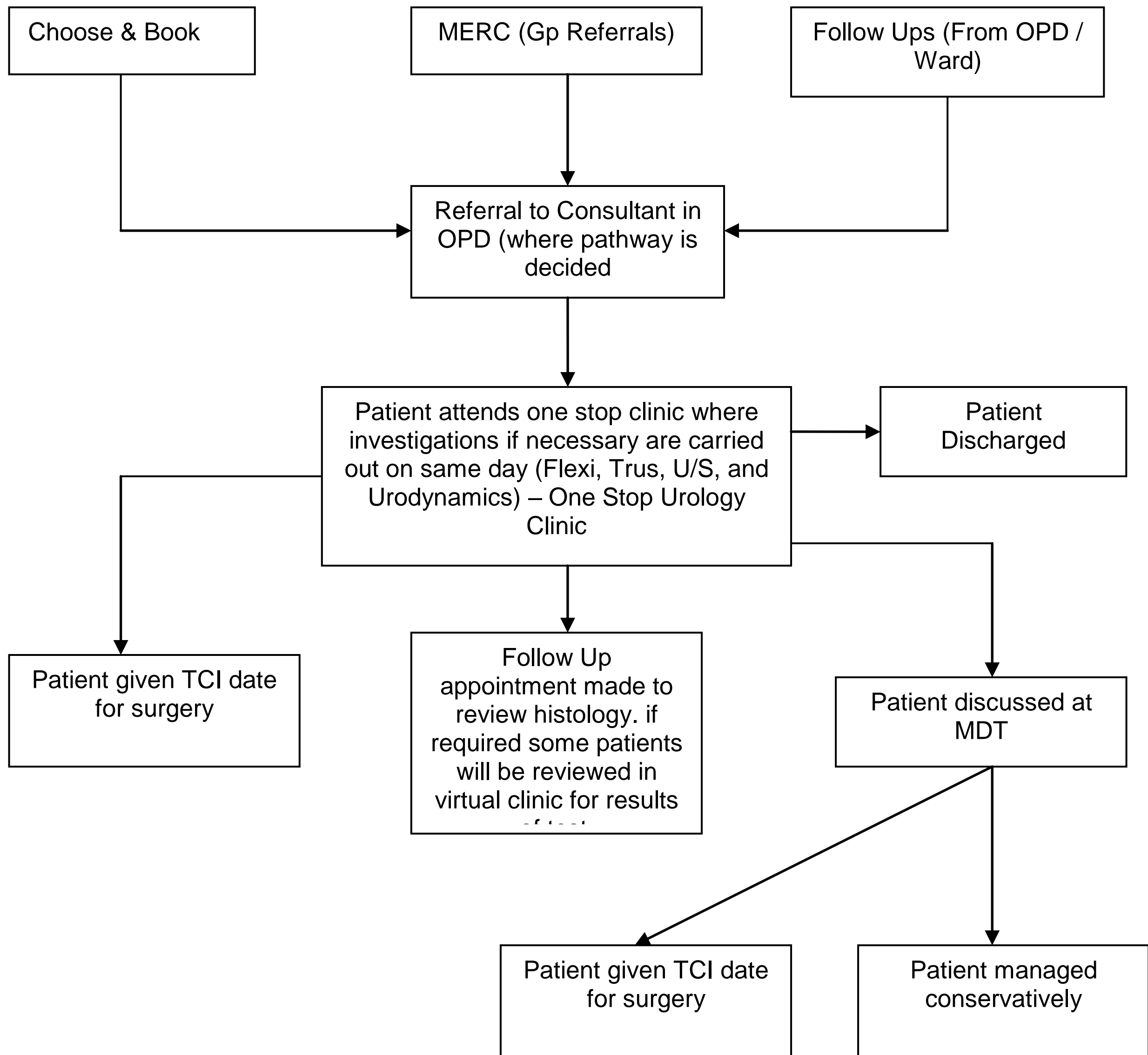
## Work Flow Diagrams: Elective Admissions

### Elective Admissions – Pathway



**Appendix 3**

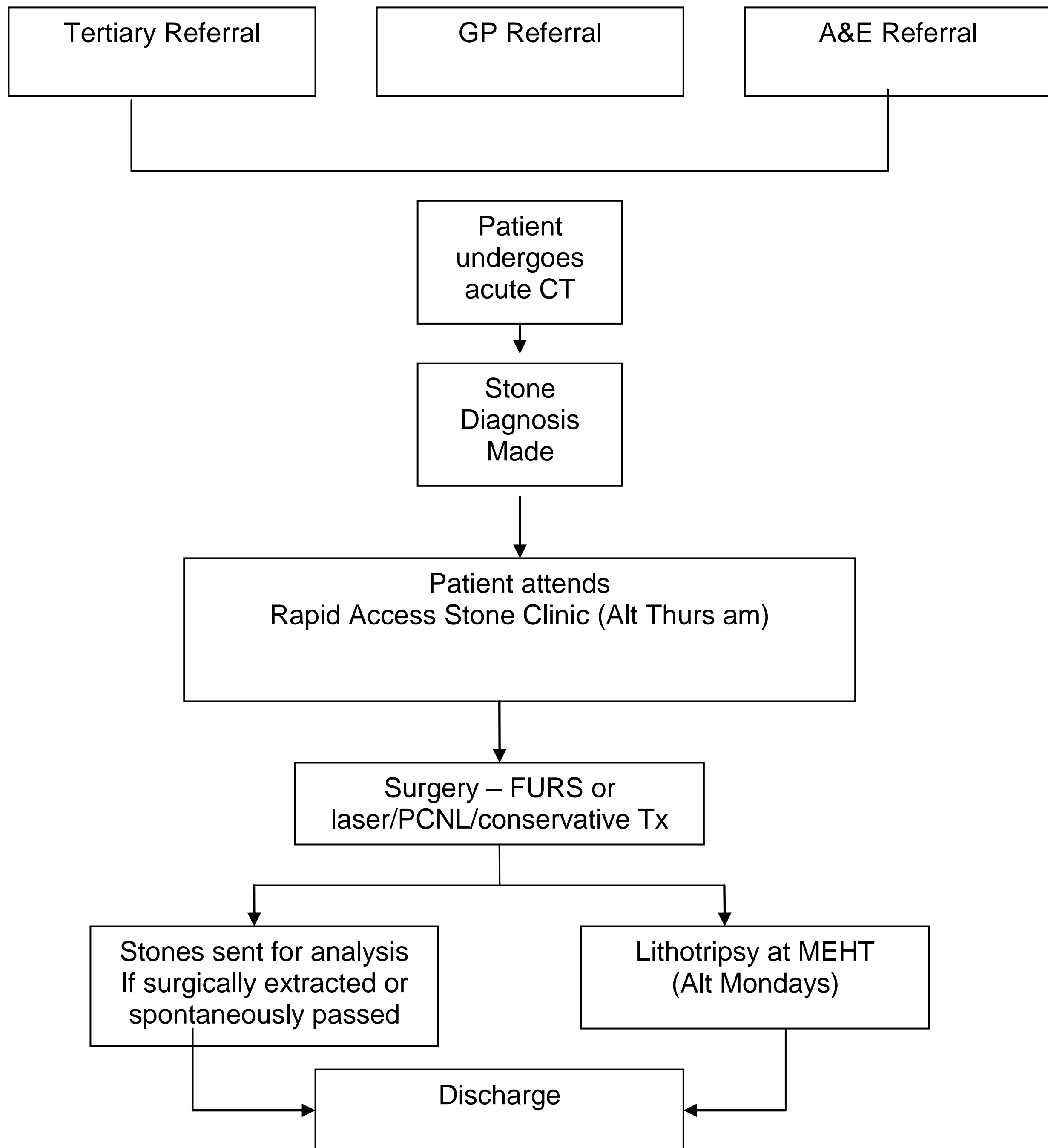
## Work Flow Diagrams: Outpatient Clinic



**Appendix 4**

**Work Flow Diagrams:**

**Renal Stone Clinic**



## PATIENT JOURNEY: LITHOTRIPSY TREATMENT FOR RENAL STONES

**Referred for Lithotripsy**

Hospital / G.P.

Hospital Appointment by Letter → Information Leaflet on Treatment

**Arrive at Hospital for Treatment**

Clinical Lead / Hospital Nursing Staff

Informed Consent gained → Contraindications checked → Pain Relief administered

**Enter Treatment Area**

Focus Medical Lithotripsy Technicians

Check I.D./ Informed Consent/ Contraindications → Position Patient on Treatment Table → Explanation of Procedure → Stone Localisation → Shock Wave Treatment / Patient Monitoring → Help Patient off Table/ Return to Recovery

**Recovery Area**

Hospital Nursing Staff

Check B.P./ Monitoring → Fluid Intake → Pass Urine → Advice on Follow-Up → Discharge Patient

© Focus Medical Services Limited 2011

**Theatre Template**

**Appendix 6**

| | Th 3 | Th 6 | Th 15 | Th 16 | Th 17 | DSU | BCH |
|---|---|---|---|---|---|---|---|
| Mon | | | | | | | |
| Am | RC | | | | | | |
| Pm | RC | | | | | KW | |
| Tue | | | | | | | |
| Am | | | | | | LM 2:4 | |
| Pm | | | | | | DS | |
| Wed | | | | | | | |
| Am | | | | MN | | | |
| Pm | | | | MN | | | DS 1:4 |
| Thu | | | | | | | |
| Am | | | | MN/DS alt | WM | | |
| Pm | | | | | PJ/JS alt | | |
| Fri | | | | | | | |
| Am | WM | | | | | | PJ 2:4 |
| Pm | KW 2:4 | | | | | DS | |

## Appendix 7: Preliminary Equality Analysis

**This assessment relates to:** (please tick all that apply)

| | | | | | |
|---|---|---|---|---|---|
| A change in a service to patients | | A change to an existing policy | **X** | A change to the way staff work | |
| A new policy | | Something else (please give details) | | | |

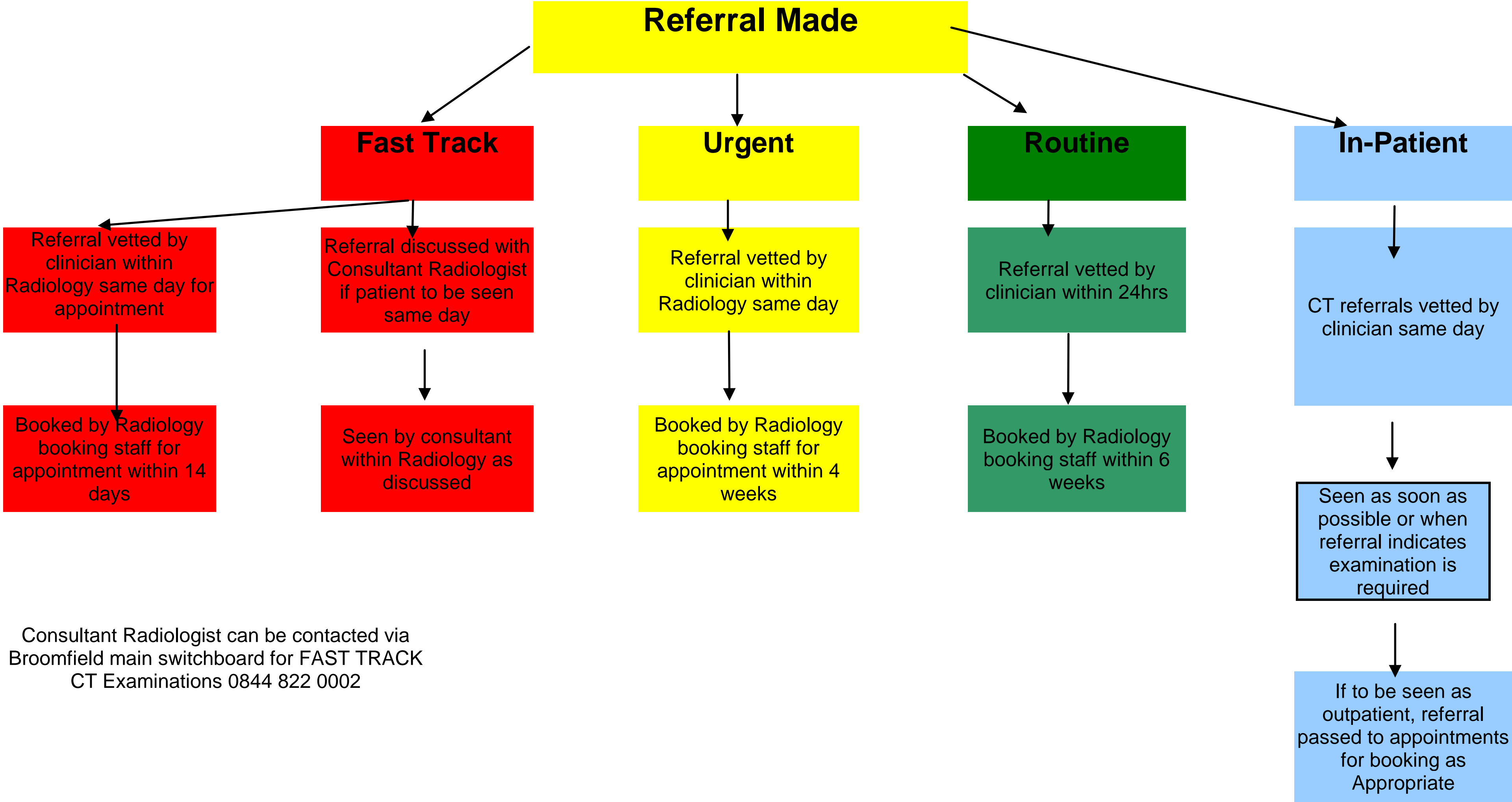
| Questions | Answers |
|---|---|
| **1. What are you proposing to change?** | Review policy |
| **2. Why are you making this change? (What will the change achieve?)** | Policy process – 3 year review |
| **3. Who benefits from this change and how?** | Clinicians & patients |
| **4. Is anyone likely to suffer any negative impact as a result of this change?** If **no**, please record reasons here and sign and date this assessment. If **yes**, please complete a full EIA. | No |
| **5. a) Will you be undertaking any consultation as part of this change?** **b) If so, with whom?** | Yes<br>Refer to pages 1 & 2 |

**Preliminary analysis completed by:**

| **Name** | Amanda Hammond | **Job Title** | Urology Nurse Specialist | **Date** | December 2018 |
|---|---|---|---|---|---|

**Elective Flows** **Radiology Flow**

Appendix 8




Consultant Radiologist can be contacted via Broomfield main switchboard for FAST TRACK CT Examinations 0844 822 0002

# Admission Criteria for Children in Mid Essex Hosptial

Appendix 9

**Sick children aged below 16 years seen in A&E**

**Is the child critically sick?**

**No**

**Yes**

**Follow guidelines for critically ill children**

**Medical**
Phoenix Ward/Paediatrics
Point of contact: Paed Reg

Newborn babies < 10 days
Ward: Newborn unit
Point of contact: Paed Reg

**Isolated Head Injures**

| < 5years | ≥5 years |
| --- | --- |
| Phoenix Ward/Paediatrics<br>Point of Contact: Paed Reg | Phoenix\Surgical<br>Point of contact: Surgical |

**ENT Problems**
Phoenix\ENT
Point of Contact: ENT team

**Surgical/Urological**

| **< 5 years** | **≥5 years** |
| --- | --- |
| Phoenix Ward/Paediatrics<br>Point of contact: Paed Registrar | Ward: Moonbeam ward<br>Point of Contact: Surgical team<br>Urological Cases<br>Point of Contact: Urology SHO/Registrar |

**Head Injury with Trauma**
**Trauma and Fractures**

Phoenix\Surgical/Ortho
Point of Contact: Surg/ Ortho team
To be decided on a case by case basis

**Revised Criteria September 2014 Dr J Cyriac**

# MEHT Urological Cancer Studies

## RCC

### NeoAdjuvant

**NAXIVA**

PHASE II NEOADJUVANT STUDY OF AXITINIB FOR REDUCING EXTENT OF VENOUS TUMOUR THROMBUS IN CLEAR CELL RENAL CELL CANCER WITH VENOUS INVASION (NAXIVA)

**Recruitment: 1 patient**
**Research Nurse: Lucy Willsher Ext. 4954**

### Adjuvant

**RAMPART**

Phase III multi-arm multistage randomised controlled platform trial of adjuvant therapy in patients at high or intermediate risk of relapse

Patients who have had their RCC resected and are classified as being at intermediate or high risk of recurrence (Leibovich score 3-11) are eligible for randomisation into RAMPART.

**Recruitment: 6 patients**
**Research Nurse: Bryan Singizi Ext. 4952**

### Advanced/Metastatic

**CALYPSO**

MEDI4736 combinations in metastatic renal cell carcinoma.

Clear cell renal cancer patients must have experienced progressive disease after exposure to VEGF targeted therapy.

Sarcomatoid cell renal cancer patients must have experienced progressive disease after exposure to VEGF targeted therapy.

**Recruitment: 8 patients**
**Research Nurse: Bryan Singizi Ext. 4952**

## Bladder

### Neo-Adjuvant

**CA017078 – IN SET UP**

A Phase 3, Randomized, Study of Neoadjuvant Chemotherapy alone versus Neoadjuvant Chemotherapy plus Nivolumab or Nivolumab and BMS-986205, Followed by Continued Post-Surgery Therapy with Nivolumab or Nivolumab and BMS-986205 in Participants with Muscle-Invasive Bladder Cancer

Previously untreated MIBC, pathologically proven MIBC (stage T2-T4a, N0, M0) not been previously treated (except for TURBT or prior treatment of NIMBC) and is deemed potentially curable by RC, and must be considered medically fit for RC and be willing to undergo RC as part of the study treatment. Participants must not have evidence of UC in upper urinary tracts (ureters or renal pelvis) or have a history of previous MIBC or UC not confined to the bladder. Prior systemic therapy, radiation therapy, or surgery for bladder cancer other than TURBT or biopsies is also not permitted.

**Research Nurse: Bryan Singizi Ext. 4952**

### Adjuvant

**CA209-UT**

A Phase 2, Randomized, Open-label Study of Nivolumab or Nivolumab/BMS-986205 Alone or Combined with Intravesical BCG in Participants with BCG-Unresponsive, High-Risk, Non-Muscle Invasive Bladder Cancer

Participants should be considered medically unfit for radical cystectomy or should have refused radical cystectomy.

Participants must not have evidence of UC in the upper urinary tracts (kidneys, renal pelves, ureters) or in the prostatic urethra. Previous or concurrent muscle invasive or disseminated bladder cancer is not permitted. Prior systemic treatment, radiation therapy, or surgery for bladder cancer other than transurethral bladder tumor resection (TURBT) or bladder biopsies is also not permitted.

**Research Nurse: Bryan Singizi Ext. 4952**

**Quality of Life After Bladder Cancer (Q-ABC)**

A comparison of patient related outcomes following radical surgery and radiotherapy

This is a prospective study of two contemporaneous cohorts of patients undergoing either cystectomy or radical radiotherapy for muscle invasive bladder cancer. The study is non – randomised - it has proven impossible to randomise between these interventions[6] and treatment selection will be by participants and clinicians. However, participants must have been eligible for both treatments so that the population being studied is representative of the patients in the future choosing between treatments. This study will provide prospective longitudinal quality of life data to describe and quantify changes from baseline in all participants

**Recruitment: 6 patients**
**Research Nurse: Yvonne Lester Ext. 6032**

# Prostate

## Adjuvant

### Arquer 007 – IN SET UP

A performance evaluation study of Arquer Diagnostics Ltd's MCM5 ELISA test in the diagnosis of prostate cancer.

The objective of this study is to validate the performance of Arquer Diagnostics Ltd's MCM5 ELISA test kit in detecting prostate cancer in semen specimens collected from patients attending urology clinics for prostate biopsy on the basis of raised PSA and/or abnormal DRE and who are selected for biopsy. Semen samples will be produced prior to the urology clinic appointment in a standard collection vessel and collected at the urology clinic. Collection will take place prior to biopsy.

**Research Nurses: Yvonne Lester Ext. 6032**

## Adjuvant

### Add-Aspirin

A phase III, double-blind, placebo-controlled, randomised trial assessing the effects of aspirin on disease recurrence and survival after primary therapy in common non-metastatic solid tumours.

Assessing the effects of aspirin on disease recurrence and survival after primary therapy in common non-metastatic solid tumours

**Recruitment: 53 patients**
**Research Nurse: Yvonne Lester Ext. 6032**

## Advanced/Metastatic

### STAMPEDE

Systemic Therapy in Advancing or Metastatic Prostate Cancer: Evaluation of Drug Efficacy.
Can adding metformin to the treatment of prostate cancer in non-diabetic patients improve life expectancy?
Can hormone injections be substituted for hormone patches to avoid some of the side effects and achieve as good disease control?

**Recruitment: 126 patients**
**Research Nurse: Sian Gibson Ext. 6318**

### ACE

A Phase IV study to evaluate cognitive function in metastatic castrate resistant prostate cancer (mCRPC) patients treated with Abiraterone Acetate + Prednisolone (AAP) or Enzalutamide (ENZ).
Understanding of the early impact of these cancer treatments, in mCRPC management, on the aspects of cognitive impairment, fatigue and depression.

**Recruitment: 6 patients**
**Research Nurse: Lizzie Dawson Ext. 4953**

## Observational

### UK Genetic Prostate Cancer Study

PrCa at or below 60 years at diagnosis
PrCa in a related pair where one is ≤ 65 years at diagnosis
PrCa at any age in a cluster with 3 or more cases
wish to have translation)
Any unaffected relatives of men who are already taking part in the study

**Recruitment: 87 patients**
**Research Nurse: Lorraine James Ext. 4891**